



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAY - 6 1993

The Honorable Albert Gore, Jr.
President of the Senate
Washington, D.C. 20510

Dear Mr. President:

I am respectfully submitting my calendar year (CY) 1994 Medicare physician fee schedule update and fiscal year (FY) 1994 Medicare volume performance standard (MVPS) recommendations. Section 1848 of the Social Security Act (the Act) requires the Secretary of Health and Human Services to make these recommendations by April 15 of each year. While I am making my recommendations at this time, I am concerned about problems in the formulas specified in the statute for determining the MVPS and update which need to be addressed for 1994.

Physician Fee Schedule Update Recommendation

I am recommending updates of 10.2 percent for surgical services, 6.6 percent for primary care services and 4.6 percent for other nonsurgical services. These updates are consistent with the President's budget, which calls for a 2.0 percentage point reduction from the current law physician fee schedule update that will go into effect if Congress does not enact the update. Under the President's proposal, primary care services would be exempt from the 2.0 percentage point reduction. If Congress does not enact the update, current law requires the Secretary to set updates of 12.2 percent for surgical services and 6.6 percent for nonsurgical services following a statutory formula.

I am recommending these updates because of my commitment to the MVPS process and the agreement forged between Congress and the physician community when the physician payment reform legislation was enacted in 1989. However, I have concerns about the relatively high updates that are produced under the MVPS as it is currently formulated. In particular, I believe the MVPS system may need to be adjusted consistent with proposals to be included in the President's health care reform plan and deficit reduction objectives. I describe the components of my recommended update in more detail in the attached report.

MVPS Recommendation

I am also recommending FY 1994 MVPS rates of increase of 9.4 percent for surgical services, 7.6 percent for nonsurgical services and 8.1 percent for all physician services. (The law requires the Secretary to recommend and publish an MVPS for all physician services. Although a separate MVPS for all physician services is published, it has no practical effect because expenditures are measured relative to the MVPS standards for surgical and nonsurgical services.) These MVPS rates of increase were determined by combining the effects of inflation, enrollment growth, the 5-year average rate of increase in the volume and intensity of services and other factors such as the effect of laws or regulations, including implementation of the Medicare physician fee schedule. After combining the effects of these factors, we subtracted a performance standard factor of 3.5 percentage points.

If the MVPS is not set by Congress, it is established by the Secretary under an automatic "default" mechanism which combines effects of inflation, enrollment growth, the 5-year average growth in the volume and intensity of services and the effect of laws or regulations. After the effects of these factors are combined a performance standard factor of 2.0 percentage points is subtracted. Consistent with the President's budget, we are recommending that the performance standard factor be increased by 1.5 percentage points to 3.5 percentage points. Our MVPS recommendation also includes the effect of other proposals made in the President's budget which, if enacted, will reduce expenditures for physician services.

We are recommending separate MVPS rates of increase for surgical and nonsurgical services consistent with the structure of current law. The high level of the FY 1994 MVPS recommendation is due, in part, to the high level of the recommended CY 1994 physician fee schedule update which is one factor in determining the MVPS. Even after incorporating reductions from the President's budget, we consider these expenditure goals to be maximums. That is, because of our concern about problems in the MVPS system, lower MVPS rates of increase may be advisable. The Department is considering legislative options for improving the MVPS statute so as to produce more realistic expenditure goals. I expect to submit a proposal in the next few weeks to restructure the framework for the updates and the spending goals that would promote primary care services and not reward excess volume and intensity for other medical and surgical services. The details of my MVPS recommendation are discussed in the attached report.

MVPS rates of increase computed using the statutory default methodology (methodology that would be used if the Congress does not enact the MVPS) would be higher than our recommended MVPS values. Specifically, the default formula in present law would yield an MVPS of 13.9 percent for surgical services, 10.8 percent for nonsurgical services, and 11.6 percent for all physician services. These figures may change later in the year based on more complete data.

Rate of Increase in Expenditures for FY 1992

As I stated earlier, I am very concerned about the high level of the update produced under current law. If Congress does not set the update, it is set under an automatic default mechanism which adjusts the Medicare Economic Index (MEI)--an inflation index for items relevant to physicians in office practice--based on expenditures relative to the MVPS.

Under the automatic default mechanism, the CY 1994 MEI is adjusted based on the rate of increase in expenditures in FY 1992 relative to the MVPS for that year. Based on our most recent data, the rate of increase in expenditures by fiscal quarter and for the full year relative to the FY 1992 MVPS was as follows:

Quarterly Rate of Increase in Expenditures

<u>Fiscal Quarter</u>	<u>Surgical</u>	<u>Nonsurgical Services</u>	<u>All Physician Services</u>
1st	1.3%	8.7%	6.7%
2nd	-1.8%	8.7%	5.8%
3rd	-6.7%	4.5%	1.6%
4th	-6.1%	6.4%	3.2%

Full Year Rate of Increase Relative to the MVPS

	<u>Rate of Increase in Expenditures</u>	<u>FY 92 MVPS</u>	<u>Difference</u>
Surgical Services	-3.3%	6.5%	-9.8%
Nonsurgical Services	7.0%	11.2%	-4.2%
All Physician Services	4.3%	10.0%	-5.7%

If Congress does not enact the update, the Secretary of Health and Human Services is required to establish the update as follows:

	<u>MEI</u>	<u>Adjustment</u>	<u>Update</u>
Surgical Services	2.4%	+9.8	12.2%
Nonsurgical Services	2.4%	+4.2	6.6%

These updates are based on our current estimate of the MEI and the most recent data regarding the rate of increase in expenditures for FY 1992. Our estimates may change based on later data. Consistent with the President's budget, I am recommending that these updates be reduced by 2.0 percentage points for all services except primary care, resulting in updates of 10.2 percent for surgical services, 6.6 percent for primary care services and 4.6 percent for other nonsurgical services.

As I have indicated already, although I am recommending updates for physician services based on the automatic default mechanism in current law adjusted for proposals included in the President's budget, I am concerned about problems with the MVPS. The FY 1992 MVPS was set under the automatic default mechanism specified in section 1848(f)(2) of the Act. It includes an allowance for the 5-year average rate of increase in the volume and intensity of services. Because volume and intensity growth was extremely high during the base period, the FY 1992 MVPS included a high volume and intensity allowance of 8.1 percent. The MVPS was increased an additional 3.0 percentage points to reflect volume and intensity that would be generated in response to payment reductions. Taken together, and after subtracting a statutory performance standard factor of 1.5 percentage points, the FY 1992 MVPS included a volume and intensity allowance of 9.6 percent.

Other factors, such as a rate of increase in volume and intensity which differed from historical trends may also explain the variation between the rate of increase in expenditures and the MVPS. We discuss these and other factors in the attached report.

As part of the President's budget and economic package, we have already proposed some changes in the MVPS system. We are proposing to change the automatic default mechanism for setting the MVPS and increase the performance standard factor to 3.5 percentage points for FY 1994 and 4.0 percentage points thereafter from its current level of 2.0 percentage points. The performance standard factor is subtracted after the MVPS is increased to account for the effects of inflation, enrollment growth, the 5-year average rate of increase in volume and intensity and changes in expenditures due to law or regulations.

The President's budget also includes a proposal to increase the maximum downward adjustment in the physician fee schedule update. Currently, the physician fee schedule update can be adjusted downward a maximum of 2.5 percentage points in 1994 and 1995 and 3.0 percentage points thereafter. There is no limit on upward adjustments to the physician fee schedule update. We are recommending that the limitation on downward adjustments in the MEI be increased to 5.0 percentage points for any succeeding year. We believe this change is necessary to reduce the asymmetry of the current adjustment.

In addition to these proposals, the Department is also developing a proposal to restructure the MVPS and update in order to provide more realistic and affordable spending goals and continued support for primary care services while not rewarding excess volume and intensity for other medical and surgical services. We expect to provide Congress with this proposal in the next few weeks.

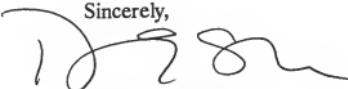
We are also submitting the report entitled "Monitoring Utilization of and Access to Services for Medicare Beneficiaries Under Physician Payment Reform." This report describes methods that are being used to monitor changes that may occur in access and utilization of physicians' services and presents the first preliminary data for 1992. The report includes six analyses underway to gain different perspectives for monitoring Medicare beneficiary access and utilization of physicians' services.

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Preliminary 1992 data analyses show a redistribution of payments, as intended by the physician fee schedule. A greater share of payments flowed from procedure-oriented services (surgery, anesthesia, assistants at surgery, diagnostic X-ray) toward primary care-oriented services (medical care, consultation) and from areas where physicians' earnings were higher (e.g., California) toward areas where physicians' earnings were lower (e.g., Mississippi). Relative rates of utilization of physician services by demographic and geographic categories remained unchanged; the Medicare fee schedule does not appear to have exacerbated any differentials in utilization rates that may have existed prior to the fee schedule.

In conclusion, I would reiterate that my recommendations with respect to the Medicare physician fee schedule update and MVPS are subject to possible revision in light of the Administration's health care reform plan and deficit reduction objectives. I look forward to working closely with Congress on these issues and others of mutual concern in the months to come.

Sincerely,



Donna E. Shalala

Enclosures (3)



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

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The Honorable Thomas S. Foley
Speaker of the House of Representatives
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Other factors, such as a rate of increase in volume and intensity which differed from historical trends may also explain the variation between the rate of increase in expenditures and the MVPS. We discuss these and other factors in the attached report.

As part of the President's budget and economic package, we have already proposed some changes in the MVPS system. We are proposing to change the automatic default mechanism for setting the MVPS and increase the performance standard factor to 3.5 percentage points for FY 1994 and 4.0 percentage points thereafter from its current level of 2.0 percentage points. The performance standard factor is subtracted after the MVPS is increased to account for the effects of inflation, enrollment growth, the 5-year average rate of increase in volume and intensity and changes in expenditures due to law or regulations.

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In addition to these proposals, the Department is also developing a proposal to restructure the MVPS and update in order to provide more realistic and affordable spending goals and continued support for primary care services while not rewarding excess volume and intensity for other medical and surgical services. We expect to provide Congress with this proposal in the next few weeks.

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Preliminary 1992 data analyses show a redistribution of payments, as intended by the physician fee schedule. A greater share of payments flowed from procedure-oriented services (surgery, anesthesia, assistants at surgery, diagnostic X-ray) toward primary care-oriented services (medical care, consultation) and from areas where physicians' earnings were higher (e.g., California) toward areas where physicians' earnings were lower (e.g., Mississippi). Relative rates of utilization of physician services by demographic and geographic categories remained unchanged; the Medicare fee schedule does not appear to have exacerbated any differentials in utilization rates that may have existed prior to the fee schedule.

In conclusion, I would reiterate that my recommendations with respect to the Medicare physician fee schedule update and MVPS are subject to possible revision in light of the Administration's health care reform plan and deficit reduction objectives. I look forward to working closely with Congress on these issues and others of mutual concern in the months to come.

Sincerely,


Donna E. Shalala

Enclosure (3)

Physician Fee Schedule Update Recommendation
For Calendar Year (CY) 1994

Background

The Omnibus Budget Reconciliation Act (OBRA) of 1989 added section 1848 to the Social Security Act (the Act). Section 1848 of the Act provides for a comprehensive package of Medicare physician payment reform that included the following provisions:

- o The reasonable charge payment mechanism which based payment on physicians' charges was replaced by a physician fee schedule beginning January 1, 1992.
- o Performance standard rates of increase are established to control the rate of growth of expenditures for physicians' services.

Under the physician fee schedule, payment for a service equals the product of the relative value unit for a service, a geographic adjustment factor, and a conversion factor. Relative value units measure the relative amount of resources used by physicians to provide different services, while the geographic adjustment factor measures practice costs differences between areas. The conversion factor converts relative value units to dollar amounts.

Under section 1848(d)(2) of the Act, the Secretary annually recommends a fee schedule update to Congress by April 15. The Physician Payment Review Commission (PPRC) reviews the Secretary's recommendation and makes its own recommendation by May 15. If Congress does not set an update by October 31, the update will be established through an automatic default mechanism as set forth in section 1848(d)(3) of the Act. Under this mechanism, the update will equal the Medicare Economic Index (MEI) increased or decreased by the number of percentage points by which actual expenditures in the second preceding fiscal year exceeded or were less than the performance standard rate of increase established for that year. The adjustment to the MEI for a category of physicians' services cannot be reduced by more than 2.5 percentage points in 1994 and 1995, and 3 percentage points in any succeeding year. There is no limit on upward adjustments to the MEI.

Section 1848(a)(2) provides for a transition from the reasonable charge payment system to the physician fee schedule for some services. For services subject to the transition, payment will be a blend of the payment under the reasonable charge payment system and the physician fee schedule amount. The transition to the fee schedule is occurring over the 1992-1996 period. By 1996, all services will be paid completely under the physician fee schedule. For services subject to the transition rules, payment in 1994 will equal 67 percent of the payment in 1993 (updated for

1994) and 33 percent of the fully implemented fee schedule amount which is computed based on the conversion factor updated for 1994. For services already paid at the fully implemented fee schedule amount, payment will be based on the updated conversion factor. The statute requires the Secretary to update both the conversion factor and the prior year's payment amount that is used for determining payments during the transition. We will refer to both updates as the physician fee schedule update.

Statutory Requirement

Pursuant to section 1848(d) of the Act, the Secretary shall provide Congress with a recommendation of a fee schedule update by April 15th of each year. The Secretary is required to consider the following factors:

- o The percentage change in the MEI (a measure of the increase in the cost of operating a medical practice);
- o The percentage by which actual expenditures for physicians' services in the first preceding fiscal year were less than or exceeded actual expenditures in the second preceding fiscal year;
- o The relationship between the percentage determined above for a fiscal year and the performance standard rate of increase for that fiscal year (this factor is to be adjusted to account for changes in the proportion of Medicare beneficiaries enrolling in health maintenance organizations (HMOs));
- o Changes in the volume and intensity of services;
- o Access to services; and
- o Other factors that may contribute to changes in volume and intensity of services or access to services.

The Secretary also may consider:

- o Unexpected changes by physicians in response to implementation of the fee schedule;
- o Unexpected changes in outlay projections;
- o Changes in the quality or appropriateness of care; and
- o Any other relevant factors not measured in the resource-based payment methodology.

Pursuant to section 1848(d)(2)(D), the Secretary's report to Congress must include the following:

- o The update recommended for each category of physicians' services and for the following groups of physicians' services: nonsurgical services, visits, consultations and emergency room services;
- o The rationale for the recommended update for each category and group of services described above; and
- o The data and analyses underlying the recommended update(s).

Section 1848(d)(2)(E) of the Act requires the Secretary to provide a statement of the percentage by which actual expenditures were less than or exceeded projected expenditures for the first preceding fiscal year. Projected expenditures are actual expenditures in the second preceding fiscal year increased by the following factors:

- o The weighted average percentage increase in payments for physicians services for the preceding fiscal year;
- o The percentage increase in the number of non-HMO Part B enrollees;
- o The average annual growth in the volume and intensity of services for the preceding 5-year period ending with the second preceding fiscal year; and
- o The percentage change in expenditures resulting from changes in law or regulations.

The projection of the baseline rate of increase for FY 1992 using the statutory formula specified above was 11.5 percent. The FY 1992 MVPS was 10.0 percent for all physician services (6.5 percent for surgical services and 11.2 percent for nonsurgical services). The difference between the projection and the MVPS enacted for FY 1992 is due to one factor: The MVPS reduces the expenditure projection by a performance standard factor of 1.5 percentage points.

We estimate that actual expenditures between FY 1991 and FY 1992 increased by 4.3 percent for all physician services or 7.2 percentage points less than the 11.5 percent projection using the section 1848(d)(2)(E) methodology. We would point out the projection of 11.5 percent for FY 1992 included a baseline adjustment for volume and intensity of services to account for anticipated responses to implementation of the Medicare physician fee schedule. The overall projection would have been about 3.0 percentage points lower had the projection not included this baseline adjustment. If projected expenditures did not include

the baseline adjustment, there would be a 4.2 percentage point difference between the rate of increase in projected and actual expenditures.

There are several possible reasons for the rate of increase in actual expenditures being less than projected expenditures including the following:

Formula for Determining Projected Expenditures

With the exception of subtracting a performance factor of 1.5 percentage points, the formula for determining the MVPS is identical to the one for determining projected expenditures. Thus, the criticisms of the formula for determining projected expenditures apply equally to the formula for determining the MVPS under the automatic default mechanism. The formula for determining projected expenditures includes an allowance for increases in expenditures based on the 5-year average rate of increase in the volume and intensity of services. Because volume growth has been high in the historical period, projected expenditures include an unacceptably high allowance for volume and intensity growth.

Projected expenditures were increased further by a baseline adjustment to reflect volume and intensity that would be generated in response to payment reductions. Taken together, these factors increase projected expenditures 11.1 percent (the 5-year average rate of increase of 8.1 percent plus 3.0 percentage points for the volume and intensity response). The statutory formula for determining the MVPS required that we subtract a performance standard factor of 1.5 percentage points from this formula for determining projected expenditures. Subtracting this performance standard factor from the 11.1 percent derived above yields a volume and intensity allowance of 9.6 percent in the FY 1992 MVPS.

Some may view the relationship between projected expenditures and actual expenditures as indicative that use of a baseline adjustment is inappropriate. This factor has been used historically, and, for prior fiscal years, use of the baseline adjustment yielded a better projection of the increase in Medicare outlays for physician services than not using one. For FY 1991, the actual rate of increase in expenditures was only 0.2 percentage points more than the projection which included the baseline adjustment for volume and intensity. For FY 1990, the difference was only 0.4 percent. We cannot say conclusively how the baseline adjustment relates to lower than expected expenditures. We have already noted that the MVPS formula allows excess volume and intensity to be incorporated into the spending goals.

Some of the other factors which may explain the low rate of increase in expenditures for FY 1992 are discussed below.

Uniform Payment Policies Adopted Under the Physician Fee Schedule

In addition to implementing the Medicare physician fee schedule which made massive changes in payments for physician services, Medicare also adopted

nationally uniform payment policies with regard to global surgical payments, medical supplies, payment for services provided in the outpatient departments of hospitals, etc. Prior to the physician fee schedule, Medicare carriers applied these policies differently in different geographic areas.

These policies were implemented in 1992 and in combination with the Medicare physician fee schedule were intended to result in budget neutral expenditures for physician services. However, it is possible that our standardized payments policies are precluding some billing opportunities for physicians. Many of the standardized payment policies did not go into effect until April 1992 which was the beginning of the third quarter of the fiscal year--this was the fiscal quarter in which the rate of increase in expenditures for physician services declined significantly. Although our policies may be resulting in a decline in the rate of increase in expenditures, it may be a 1-year effect only and the expenditures may continue increasing next year at historical rates.

Variation in the Rate of Increase in Volume and Intensity

The rate of increase in volume and intensity of services can vary substantially from year to year. For instance, the 1992 Annual Trustees Report of the Supplementary Medical Insurance Trust Fund reports significant variation in volume and intensity of services for aged Medicare beneficiaries between 1985 (3.4 percent) and 1986 (10.0 percent). The volume and intensity increase was 5.2 percent in 1989 but increased to 9.7 percent in 1990. Similar to 1985 and 1989, the rate of increase in volume and intensity in FY 1992 appears to be significantly less than Medicare's historical experience.

Other Factors

We are continuing to examine the effect of other factors which may explain the rate of growth in Medicare physician expenditures relative to the MVPS during FY 1992. For instance, Medicare identifies when beneficiaries are entitled to health benefits through an insurer other than Medicare. (A beneficiary may have health insurance through an employer or be entitled to workers compensation if they have an on-the-job injury or health benefits through an auto insurance policy if they are injured in an auto accident.) In these situations, Medicare will be the secondary payor and another insurer will be the primary payor. It is possible that improved administration of the Medicare secondary payor program as a result of our work with the Internal Revenue Service and revised questions about non-Medicare insurance coverage on Medicare's new claim form, has resulted in savings in FY 1992 relative to prior years.

We have also considered the accuracy of some of the assumptions and data used in setting payment rates under the Medicare physician fee schedule. As explained below, we were required to implement this new payment system for physician services in a budget neutral manner. To set a budget neutral physician fee

schedule, we had to make assumptions about the rate at which physicians would submit claims with charges below Medicare's allowance. A new system for coding medical visits also became effective in 1992. Thus, we had to make assumptions about how physicians would code claims for medical visits. Because full-year data was not available, we also had to base the budget neutral payment rates on our estimate of "aged" 1989 (the most recent year available) expenditures.

We have reviewed physician coding of medical visits relative to our predictions and have verified the accuracy of our assumptions in the aggregate. With regard to the other factors, we believe errors in our assumptions would have a uniform effect on expenditures throughout the fiscal year. However, because the data shows an uneven rate of increase as the fiscal year progresses, we do not believe that our assumptions with regard to actual charges below the physician fee schedule amount and the aging of the data explain the slower rate of growth in FY 1992 physician expenditures.

In summary, we cannot state with certainty why expenditures increased less than anticipated. Given the multitude of policy changes occurring in 1992 and the historic variation in volume and intensity, it is very difficult to determine with precision the effect of the different factors on expenditure growth. We are convinced, however, that the MVPS was set too high and that Congress should consider making changes in the automatic default mechanism to set more appropriate rates of increase.

1994 Physician Fee Schedule Update

The following sections discuss the factors considered in the development of the CY 1994 physician fee schedule update.

The Percentage Change in the MEI

The MEI is a measure of inflation in selected factors that are most relevant to physicians in office practice. The physician practice expense component has a weight of 45.8 percent and comprises such factors as non-physician employee compensation, office expenses, medical materials and supplies, professional liability insurance, medical equipment and other professional expenses. The physician's own time (net income, general earnings) component has a weight of 54.2 percent and comprises increases in average hourly earnings for private sector non-farm workers and fringe benefits. Both factors in the physician's own time component are adjusted for increases in productivity. Annual increases in these factors are measured to arrive at the MEI. Our most recent estimate of the MEI for CY 1993 is 2.4 percent. However, our current MEI estimate could change between now and when the CY 1994 physician fee schedule update is determined because of use of updated economic data.

Percentage Growth in Actual Expenditures

Section 1848(d)(2)(A)(ii) of the Act requires the Secretary to consider the percentage growth in actual expenditures from the second preceding fiscal year to the first preceding fiscal year for physicians' services. (We have defined physicians' services for the purposes of the fee schedule update and performance standard rates of increase in our notices of the FY 1990, FY 1991 and FY 1992 performance standard rates of increase published in the Federal Register on December 29, 1989 [54 FR 53818], December 28, 1990 [55 FR 53356], November 25, 1991 [56 FR 59813], and November 25, 1992 [57 FR 56171].)

Our current estimate of the percentage growth in physicians' services between the second preceding fiscal year, FY 1991, and the first preceding fiscal year, FY 1992, is 4.3 percent for all physician services, -3.3 percent for surgical services and 7.0 percent for non-surgical services. These estimates may change when more complete data become available later this year.

Performance Relative to the MVPS

Performance relative to the MVPS is illustrated in the table below:

FY 1992 Quarterly Rate of Increase in Expenditures

Quarter	Nonsurgical All Physician		
	Surgical Services	Services	Services
1st	1.3%	8.7%	6.7%
2nd	-1.8%	8.7%	5.8%
3rd	-6.7%	4.5%	1.6%
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FY 1992 Full Year Rate of Increase Relative to the MVPS

	Rate of Increase in Expenditures	FY 92 MVPS	Difference
Surgical Services	-3.3%	6.5%	-9.8%
Nonsurgical Services	7.0%	11.2%	-4.2%
All Physician Services	4.3%	10.0%	-5.7%

Section 1848(f)(3) of the Act requires the Secretary to monitor compliance with the performance standard and provide reports to Congress. This report of the percentage increase in expenditures between FY 1991 and FY 1992 addresses this requirement for FY 1992.

Changes in Volume and Intensity

The FY 1992 performance standard included an allowance for this factor. We do not have any evidence that the update should be further adjusted to account for this factor.

Access to Services

Our report, "Monitoring Utilization and Access to Services for Medicare Beneficiaries Under Physician Payment Reform," discusses our efforts and future plans to monitor utilization and access. In summary, we do not have any evidence of a national problem of access to care for Medicare patients nor have we seen any evidence of substantial problems at any local level. Furthermore, we would note that participation and assignment rates in recent years have continually increased and are now at an all time high. Thus, we do not believe the update factor should be increased for this factor. However, we will continue to monitor access which will include obtaining data from the Current Beneficiary Survey (an ongoing survey of current Medicare beneficiaries) to assist us and the Congress with future fee schedule updates.

Unexpected Changes by Physicians in Response to Fee Schedule Implementation and Unexpected Changes in Outlay Projections

On January 1, 1992, Medicare replaced the reasonable charge payment system with a physician fee schedule. Under the physician fee schedule, payments are generally being reduced for procedural services (e.g., surgical services, radiology services and anesthesia services) and increased for medical visits and consultations. Payments are also being significantly redistributed between geographic areas under the fee schedule. We were required to implement the physician fee schedule in a budget neutral manner (i.e., aggregate expenditures under fee schedule should equal payments under the reasonable charge payment system had it continued).

In setting budget neutral payment rates under the Medicare physician fee schedule, we assumed that "losing" physicians would respond to payment reductions by increasing the volume and intensity of services so as to offset 50 percent of the reductions in net practice revenue that would otherwise occur. To ensure budget neutral payments assuming this volume and intensity response, we reduced the fee schedule conversion factor by 3.0 percent for 1992.

We do not believe the data regarding the low rate of increase in expenditures substantiate or disprove the existence of a volume offset. However, we would note that the rate of increase in expenditures declined between the second and third quarters of the fiscal year (the first two quarters that the physician fee

schedule was in effect) and increased between the third and fourth quarters. We would have expected a consistently low rate of increase in expenditures during the fiscal year quarters the physician fee schedule was in effect if the anticipated volume and intensity response did not occur. We do believe it is possible that unanticipated volume reductions occurred as a result of implementation of the standardized payment policies (i.e global surgery) adopted under the physician fee schedule and that the volume offset could have been overstated. These policies are discussed above in more detail.

Changes in the Quality or Appropriateness of Care

As we explained in our update recommendation for CYs 1992 and 1993 and this year's CY 1994 MVPS recommendation, we are concerned about inappropriate utilization of specific procedures and administrative practices such as unbundling and upcoding which have the effect of increasing expenditures for Medicare services. However, we do not expect studies of inappropriate utilization to yield precise results which will allow us to account for this factor in either our recommendations of a fee schedule update or the performance standard rates of increase. However, we will continue to study the extent of inappropriate utilization and aberrant billing practices. We expect our studies will provide useful insights regarding inappropriate utilization and will ultimately lead to improvements in the practice of medicine.

Update Recommendation for CY 1994

Our update recommendation for CY 1994 attempts to reconcile three competing principles. First, we want to ensure that the fee schedule fulfills its promise to shift payments from procedure oriented services to primary care and other cognitive services. Second, we want to demonstrate our commitment to the MVPS process by honoring the implicit agreement with physicians to adjust the 1993 update by actual performance against the published standards. Third, we believe the physician fee schedule update should reflect the President's deficit reduction goals.

Having considered these goals, we decided to make a recommendation for CY 1994 consistent with the structure of present law which establishes separate updates for surgical and nonsurgical services under an automatic default mechanism that adjusts the MEI based on expenditures relative to the MVPS. However, consistent with the President's budget submitted earlier this year, we are recommending that the updates under the automatic default mechanism be reduced by 2.0 percentage points for all services except primary care. Thus for 1994 we are proposing three update amounts, while leaving the underlying statutory structure, which calls for two updates, intact.

The MVPS for FY 1992 was 6.5 percent for surgical services and 11.2 percent for nonsurgical services. Expenditures between FY 1991 and FY 1992 increased by -3.3 percent for surgical services (or 9.8 percentage points less than the MVPS for surgical services) and 7.0 percent for nonsurgical services (or 4.2 percentage points less than the MVPS for nonsurgical services). Our current estimate of the MEI is 2.4 percent. Thus, we are recommending updates based on the automatic default mechanism and subtracting 2.0 percentage points for all services except primary care as follows:

	<u>Surgical Services</u>	<u>Nonsurgical Services</u>	<u>Primary Care Services</u>
MEI	2.4%	2.4%	2.4%
Performance Adjustment	9.8%	4.2%	4.2%
Default Update	12.2%	6.6%	6.6%
President's Budget Adjustment	-2.0%	-2.0%	0.0%
Recommended Update	10.2%	4.6%	6.6%

As discussed above, our update recommendation may need to be adjusted for any changes in our estimate of the MEI or of expenditure performance based on more complete data. We would further note that the President will shortly submit a health care reform proposal to Congress. Our update recommendation should be adjusted as needed in order to be consistent with proposals included in the President's health care reform plan.

We believe the level of the physician fee schedule update warrants further comment. These updates are being recommended because of the Department's commitment to the MVPS process and the agreement forged between Congress and the physician community when legislation including the MVPS was enacted. However, the Department is very concerned about the relatively high updates produced under the automatic default mechanism. We believe there are several factors which explain the high level of the current law update, which are discussed above and in the letter transmitting this report. Consistent with the President's budget, we are recommending changes in the automatic default mechanism for determining the MVPS. This change is discussed in the letter transmitting this report and in the accompanying report describing the Department's MVPS recommendation.

The Department also believes the process for making adjustments in the physician fee schedule update is also flawed by limiting downward adjustments to 2.0 percentage points in 1993, 2.5 percentage points in 1994 and 1995 and 3.0 percentage points for any succeeding year. The statute does not provide a limit to upward adjustments in the physician fee schedule update. The President's budget proposes that the limitation on downward adjustments in the MEI be increased to 5.0 percentage points for 1995 any succeeding year.

Section 1848(d)(2)(D) requires the Secretary to recommend an update for each "category of physicians' services...and for each of the following groups of physicians' services: nonsurgical services, visits, consultations, and emergency room services." We are recommending separate updates only for surgical services, primary care services (which include office visits and emergency room visits but not hospital visits and consultations) and other nonsurgical services. A separate update is being recommended for primary care services because of the Department's belief that they are important to health care reform. We believe that these services should be exempt from the adjustment made to meet deficit reduction goals.

The statute requires that the differential update for surgical and nonsurgical services be applied on a procedure-specific basis without regard to physician specialty. On May 3, 1990, we defined surgical services in the Federal Register [55 FR 18668] for the purposes of the MVPS to include surgical services that are performed by surgical specialists and stated our intention to define surgical services on a procedure-specific basis. On November 25, 1992, we published a final notice with comment of our revised definition in the Federal Register [57 FR 56168] for the purposes of the update for CY 1993 and subsequent years and for measuring expenditures under the MVPS beginning with FY 1994. We also published a list of the services which are considered surgical under our revised definition. Based on the comments received, we will consider making changes in the list of services which are considered surgical for the purposes of the physician fee schedule update. We will publish changes to the list of surgical services in the Federal Register notice announcing the physician fee schedule update and MVPS expected to be published in October 1993.

**Medicare Volume Performance Standards Recommendation
for Fiscal Year (FY) 1994**

Background

Section 6102 of the Omnibus Budget Reconciliation Act (OBRA) of 1989 (P.L. 101-239) added section 1848, Payment for Physicians' Services, to the Social Security Act (the Act). Section 1848(f) of the Act establishes the Medicare volume performance standard (MVPS), which is a system for establishing goals for the rate of growth in expenditures for physicians' services. The MVPS rates of increase are not limits on expenditures. Payments for services will not be withheld if performance rates of increase are exceeded. Rather, the success or failure in meeting the performance standard would be one of the factors considered in setting the annual fee update in a subsequent year.

The Secretary of Health and Human Services is required to recommend to Congress by April 15 of each year the performance standard rates of increase for the fiscal year beginning in that calendar year. The MVPS recommendation being made in this report is for FY 1994, i.e., the year beginning October 1, 1993, and ending September 30, 1994. In making the recommendation the Secretary is required to consider:

- o Inflation,
- o Changes in the number of enrollees,
- o Aging of enrollees,
- o Changes in technology,
- o Evidence of lack of access to physicians' services,
- o Evidence of inappropriate utilization of services, and
- o Other factors that the Secretary considers appropriate.

The Physician Payment Review Commission (PPRC) is required to review the Secretary's recommendation and make its own recommendation to Congress by May 15. If Congress does not establish an MVPS for a fiscal year by October 31, the MVPS rates of increase will be established through an automatic default mechanism as set forth in section 1848(f)(2)(A) of the Act. Under this mechanism, the MVPS rates of increase would equal the product of the following factors, less an adjustment described below:

- o The estimate of the weighted average percentage increase in physicians' fees for calendar years included in the fiscal year involved,
- o The estimate of the percentage increase or decrease in the average number of enrollees (excluding risk HMO enrollees) from the previous fiscal year to the fiscal year involved,

- o The Secretary's estimate of the average annual percentage growth in volume and intensity of physicians' services for the 5-fiscal year period ending with the preceding fiscal year, and
- o The Secretary's estimate of the percentage increase or decrease in expenditures for physicians' services resulting from changes in law or regulations.

This product is then reduced by a performance standard factor set by statute. This factor is 2.0 percentage points for all fiscal years after 1992. The table below shows the MVPS rates of increase established for FY 1990 - FY 1993.

Performance Standard Rates of Increase for Prior Years

	<u>All Services</u>	<u>Surgery</u>	<u>Nonsurgery</u>
FY 1990*	9.1	-	-
FY 1991**	7.3	3.3	8.6
FY 1992***	10.0	6.5	11.2
FY 1993***	10.0	8.4	10.8

* The performance standard rate of increase for FY 1990 was 9.1 percent for all physicians' services and was computed in accordance with section 1848(f)(1)(D) of the Act, which did not require separate performance standards for surgical and nonsurgical services. Beginning with FY 1991, we are required to establish separate performance standards for surgical and nonsurgical services.

** In November 1990, Congress specified in OBRA 1990 the methodology for determining the FY 1991 MVPS only. The 5.3 percentage point difference between surgical and nonsurgical procedures is largely due to OBRA 1990 provisions which had the effect of reducing payments for surgical services and expanding benefits or increasing payments for certain nonsurgical services.

*** The FY 1992 and FY 1993 MVPS were calculated using the automatic default mechanism specified in section 1848(f)(2)(A) of the Act.

Note: The law requires the Secretary to recommend and publish an MVPS for all physician services. Although a separate MVPS for all physician services is published, it has no practical effect because expenditures are measured relative to the MVPS standards for surgical and nonsurgical services.

Definition of Surgical Services

We announced our definition of surgical services for MVPS purposes in the Federal Register on May 3, 1990 [55 FR 18668]. At that time, we defined surgical services as:

- o All services classified as type of service "surgery" in the Medicare payment record that are performed by specified surgical specialists, and
- o All services currently classified as type of service "assistant at surgery" in the Medicare payment record.

We are using this definition to measure annual growth in expenditures for surgical and nonsurgical services relative to the FY 1992 performance standard rates of increase. Our definition is being used to estimate expenditure growth relative to each performance standard and not to classify individual services as surgical or nonsurgical. However, in our notice on May 3, 1990, defining surgical services, we stated that any differential in the annual update because of separate performance standards would be applied on a procedure-specific basis without regard to specialty.

As indicated in our update recommendation, for the purposes of the 1993 update, we revised this definition in a final notice with comment on November 25, 1992 [57 FR 56168]. We also stated our intention to use this revised definition for the purposes of measuring expenditures under the MVPS beginning with FY 1994. In our November 25, 1992 Federal Register notice, we provided a listing of services that are considered surgical for the purposes of the 1993 update. Under our revised definition of surgical services, a service is considered surgical if:

- o In the HCFA Part B data system, the service is classified under "type of service" as a "surgery" and,
- o The service is performed by surgical specialists more than 50 percent of the time.

To avoid double counting each occurrence of a surgery, we are not including the services of an assistant at surgery in classifying the surgical or nonsurgical. Based on the comments received on our November 25, 1992, notice, we may make changes in the listing of surgical services. If we make changes in the listing of surgical services, they will be announced in the Federal Register notice announcing the FY 1994 MVPS and CY 1994 physician fee schedule update expected to be published in October.

Categories of Services Subject to Separate Performance Standards

For FY 1994, we are recommending separate performance standards for surgical services and other services, consistent with the default standards in current law. The factors we considered for our FY 1994 recommendation are described below.

Inflation

Our estimate of this factor is based on the Medicare Economic Index (MEI)--a measure of inflation of the items most relevant to physicians' in office practice. Our most recent estimate of the MEI for CY 1994 is 2.4 percent. Our current MEI estimate may change between now and when the FY 1994 MVPS is established, based on updated economic data.

Similar to our recommendation last year, we are considering two other factors which will have an effect on the general level of physicians' fees in FY 1994:

- o Laboratory services are updated by the Consumer Price Index (CPI). The weighted average CPI for the calendar years included in FY 1994 is currently estimated to be 3.1 percent. Although Congress mandated a lab update of 2.0 percent for 1993, we are including the effect of the difference between the lab update and the CPI in the legislative factor described below, and
- o Participating physicians (physicians who agree to accept the Medicare allowance as payment in full and charge the beneficiary only the remaining portion of their deductible or the 20 percent coinsurance amount) are paid 5 percent more for their services than nonparticipating physicians. Participation rates have climbed steadily each year and we assume that this trend will continue.

When all of these factors are considered, the weighted composite inflationary effect on physicians' fees is estimated to be 2.6 percent for surgical services, and 2.7 percent for nonsurgical services. This number is based on the most current projections now available. Changes in the economic projections and the MEI methodology between now and October--when the MEI update is usually calculated--may affect this figure.

Enrollment

Average Medicare Part B enrollment in FY 1994 is estimated to be 34.93 million. Decreasing that figure by estimated enrollment in risk health maintenance organizations (HMOs) of 1.85 million results in a net figure of 33.08 million Part B enrollees in FY 1994. The corresponding figures for FY 1993 are 34.27 million, 1.63 million, and 32.64 million, respectively. This yields an increase exclusive of risk HMO enrollees of 440,000 beneficiaries, or 1.3 percent, for surgical and nonsurgical services.

Aging

We are estimating that the age of the average Medicare beneficiary will increase, contributing slightly to increasing Medicare expenditures. Aging of the Medicare

population would add 0.1 percentage points to the MVPS standards for surgical and nonsurgical services in FY 1994.

Technology

As the Department has stated in prior years, we do not expect to be able to quantify the effects of technology on expenditure growth in the near future. While improvements in our data systems will be helpful for tracking year to year increases in expenditures for specific procedures, we do not believe it will be possible to isolate the effects of technology because rates of growth can be attributed to many factors. However, we remain interested in improving our understanding of how technological innovation affects Medicare spending.

Inappropriate Utilization

We reviewed several studies of inappropriate utilization for our FY 1991 MVPS recommendation. Although we remain concerned about inappropriate utilization of specific procedures and the extent of geographic variation in utilization, we cannot quantify its effects based on limited data for our MVPS recommendation. We also continue to be concerned about billing practices such as upcoding (billing for a service at a higher level than what was rendered) and unbundling (billing for additional services which were previously included in a single bill) which may have the effect of inappropriately increasing expenditures for physician services.

As required by section 1848(g)(7) of the Act, our annual report on access and utilization discusses the Department's long term strategy for addressing these issues. Our 1993 report provides preliminary information about changes in access and utilization after fee schedule implementation. No evidence of systemic or widespread lack of access is presented in the report. Furthermore, the Agency for Health Care Policy and Research (AHCPR), Public Health Service, is continuing to assess the appropriateness and effectiveness of particular Medicare services to assist in improving medical practice. We expect our future annual reports on access and inappropriate utilization and the work of AHCPR to provide additional useful information regarding inappropriate utilization in the future. However, we are doubtful that studies of inappropriate utilization will provide us with results that can be used for quantifying its effects for the MVPS recommendation.

Access

As stated in last year's MVPS recommendation, we expect a national survey of current Medicare beneficiaries which began in September 1991 to provide useful information on access to services. Furthermore, we also address issues of lack of access through our annual report to Congress on access and utilization.

We would also note that policies already exist to improve beneficiary access to services. The participating physician program gives physicians incentives to accept the Medicare allowance as payment in full. Participation rates have increased in every year since the inception of the program. Additionally, physicians providing services to Medicare beneficiaries in health professional shortage areas can receive a bonus of 10 percent of the Medicare allowance. Congress has also established a variety of other health professional resource programs (such as the National Health Service Corps) which give physicians incentives to practice in medically underserved areas.

Our report on utilization and access indicates how we will continue to monitor beneficiary access to services as the physician fee schedule is implemented. The preliminary data analyzed in the 1993 report do not substantiate the need for a specific factor for access to be included in this year's MVPS.

Other Factors

In our FY 1994 recommendation, we are considering three other factors in addition to the factors specified in the statute: (1) the FY 1994 impact of the transition to the fully implemented physician fee schedule on January 1, 1996, including the effect of refinements in the relative value units for 1993, (2) the effect of the Department's recommended CY 1994 physician fee schedule update if it were to be enacted by Congress, (3) the effect of other proposals included in the President's budget that will have an effect on expenditures for physicians' services in FY 1994.

Transition to the fully implemented physician fee schedule, after including the effect of refinements in the relative value units, will have a differential effect on the performance standard for surgical and nonsurgical services: Implementation of the physician fee schedule will have the effect of reducing the payment amounts for most surgical services. The performance standard for surgical services will be reduced due to this factor.

Payments under the physician fee schedule will increase for many nonsurgical services (i.e., office visits and consultations) and decrease for many other nonsurgical services (i.e., radiology, pathology, and other procedural oriented nonsurgical services). These factors will result in a net increase in the performance standard for nonsurgical services.

We are also including an adjustment to account for the Secretary's recommended CY 1994 physician fee schedule update. As explained in the accompanying report, we are recommending updates of 9.4 percent for surgical services, 6.6 percent for primary care services and 4.6 percent for other nonsurgical services.

The President's budget includes several proposals which will have an effect on expenditures for physician services in FY 1994. Proposals limiting the lab fee update to 2 percent and setting lab rates at market levels will have the effect of reducing expenditures for nonsurgical services. Providing a single fee for surgical services and not providing separate payment for use of an assistant at surgery would have the effect of

reducing the MVPS for surgical services only. Developing resource-based practice expense relative value units would have the effect of reducing the MVPS for both surgical and nonsurgical services.

The net effect of these three provisions on the recommended MVPS rates of increase are 2.2 percentage points for surgical services, 0.5 percentage points for nonsurgical services and 0.9 percentage points for all physician services.

Recommendation

Our MVPS recommendation for FY 1994 is consistent with the structure of present law, which calls for separate treatment of surgical and nonsurgical services. However, we have concerns about the formula for determining the MVPS under the automatic default mechanism. In particular, we are concerned that the automatic default mechanism includes an allowance for increases in expenditures based on the 5-year average rate of increase in the volume and intensity of services. Because volume growth has been high in the historical period, the MVPS includes an unacceptably high allowance for volume and intensity growth. The MVPS was increased further by a baseline adjustment to reflect volume and intensity that would be generated in response to payment reductions. Taken together, these factors resulted in an excessive allowance for volume and intensity in the FY 1992 MVPS of 9.6 percent (the 5-year average rate of increase of 8.1 percent, plus 3.0 percentage points for the volume and intensity response, less the 1.5 percentage point performance standard factor).

We believe the MVPS was set too high and is one possible explanation for the high updates that will be established under the automatic default mechanism if Congress does not enact the update. To set more appropriate MVPS rates of increase, we urge Congress to consider alternatives to including the allowance for the 5-year average rate of increase in volume and intensity of services in the automatic default mechanism. We propose, consistent with the President's budget, that Congress modify the automatic default mechanism and increase the performance standard factor to 3.5 percentage points for FY 1994 and 4.0 percentage points thereafter from its current level of 2.0 percentage points.

We recommend combining the effects of inflation, enrollment, legislative provisions and the 5-year average rate of increase in the volume and intensity of services and subtracting a performance standard factor. Consistent with the President's budget, we are recommending that Congress increase the current performance standard factor from 2.0 to 3.5 percentage points for FY 1994. Inflation, enrollment, legislation and the 5-year average rate of increase in volume and intensity are estimated to have an effect of 12.9 percent for surgical services, 11.1 percent for nonsurgical services and 11.6 percent for all physician services. Subtracting a performance standard factor of 3.5 percentage points yields our recommended rates of increase of 9.4 percent for surgical services,

7.6 percent for nonsurgical services and 8.1 percent for all physician services (a summary table of the factors in deriving the estimate is attached). We consider these expenditure goals, even after accounting for proposals in the President's budget, to be maximums. Because of our concern about problems in the MVPS system, lower MVPS rates of increase may be advisable.

Although we are recommending MVPS rates of increase based on the President's budget recommendation using a larger performance standard factor, we continue to have strong reservations about including an allowance for the 5-year average rate of increase in volume and intensity of services. We are studying alternatives to the current volume and intensity allowance under the automatic default mechanism and will propose changes to the formula in the next few weeks.

Estimate of Factors Affecting FY 1994 MVPS*

	<u>Surgery</u>	<u>Nonsurgery</u>	<u>All Services</u>
Inflation	2.6	2.7	2.7
Enrollment	1.3	1.3	1.3
Volume and Intensity	6.3	6.3	6.3
Legislation	2.2	0.5	0.9
Performance Standard Factor	-3.5	-3.5	-3.5
Total	9.4	7.6	8.1

Note: Our recommendation should be adjusted to account for changes in pricing and benefits resulting from legislation enacted this year, if any, affecting FY 1994 Medicare physician outlays other than those currently proposed in the President's budget and taken into account in this recommendation. Additionally, our recommendation should also be adjusted to reflect any changes in our estimate of the MEI for 1994.

* The effects of inflation, enrollment, volume and intensity and legislation are combined multiplicatively and the performance standard factor is subtracted.

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